LOS ALAMITOS CARDIOVASCULAR / PERFORMANCE VEIN INSTITUTE

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named herein to release confidential medical information and records. Note: *Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions or alcohol/substance abuse have special rules that require specific authorization. Treatment, payment, enrollment of eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.*

____

Full Name of Patient (First, Middle, Last) and other names used

______________________ ______________________

Street Address | City, State, Zip Code

______________ ______________ ______________

Primary Phone Number | Medical Record Number | Date of Birth

The medical information/records will be used for the following purpose:

____

This authorization is:

☐ Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)

☐ Limited to the following medical information: ______________________

I also consent to the specific release of the following records (initial to indicate consent):

Drug/Alcohol/Substance Abuse ________ HIV Diagnosis/Treatment ________

Psychiatric/Mental Health ________ Genetic Information ________

Tests for Antibodies to HIV ________

DURATION

This authorization shall be effective immediately and remain in effect until ____________________
Date

RESTRICTIONS

- Permissions for further use of disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required by law.
- A copy of this authorization is as valid as an original.
- I have been advised of my right to receive a copy of this authorization.

(continued from reverse side)

Please ***REQUEST*** Medical Information ***FROM***:

Name of Health Care Provider ______________________________

Name of Medical Office/Group/Hospital ______________________________

Street Address ______________________________

City, State, Zip Code ______________________________

Phone ______________________________ FAX ______________________________

Please ***SEND*** Medical Information ***TO***:

Name of Person or Entity Authorized to Receive Information ______________________________

Title (Examples: Physician, Therapist, Attorney) ______________________________

Street Address ______________________________

City, State, Zip Code ______________________________

Phone ______________________________ FAX ______________________________

I hereby authorize ______________________________ (per "REQUEST" above) to release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

______________________________ ______________________________
Signature of Patient or Legal/Personal Representative Date

______________________________ ______________________________
Print Name Relationship, if other than patient

______________________________ ______________________________
Print Name of Witness Signature of Witness